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The President of the Senate
The Speaker of the House of Representatives
The Secretary-designate of Health and Human Services

This summary report on the Department of Health and Human Services is one in a series that addresses major policy, management, or program issues facing agency heads in the new administration. Dealing with the issues identified will be critical if the Department is to effectively serve the millions of Americans dependent on it for benefit payments and services. Some of our concerns are relatively new, while others represent long-standing and unresolved problems.

This report highlights actions that should be taken in four critical areas affecting the large and diverse operations of the Department. These include improving departmental management, containing the cost of health care, enhancing the financing and delivery of social security benefits, and implementing the recently enacted welfare reform legislation.

The issues and suggested actions pertaining to improving departmental management and the delivery of social security benefits are drawn from our general management reviews of the Social Security Administration and the Department as a whole.

Charles A. Bowsher

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Managing the Department

The Secretary of Health and Human Services (HHS) manages the largest budget in the federal government, leads a workforce of over 120,000 people, and directs or operates more than 200 health and welfare programs. To carry out these mammoth responsibilities, the Secretary must rely on HHS's staff and management processes, structures, and systems. Breakdowns in any of these can cause failures in ongoing programs, frustrate new initiatives, and leave the Secretary vulnerable to public criticism.

Several management areas at HHS should be strengthened in order to avoid such a breakdown. HHS should invest in Department-wide planning, its personnel, and its financial and information management. HHS can eliminate role confusion among its senior executives by restructuring the role of the Department's Chief of Staff.

Initiate Departmental Planning

HHS does not have a process for steering the Department's programs and operations into the future. The lack of such a process handicaps program coordination because various Department components share no common vision or strategy for the future. Past departmental planning processes have helped the Secretary and other top

leaders influence the wide range of departmental programs and activities. We believe such planning could help in the future.

Planning within HHS varies by component. The Social Security Administration (SSA) recently developed a strategic plan for its operations for the year 2000—a vision of what service delivery will look like in a decade. Similarly, the Food and Drug Administration (FDA) has developed a 2-year action plan establishing key commissioner goals and strategies to achieve them. Other components, such as the Health Care Financing Administration (HCFA) and the Family Support Administration, focus their plans primarily on current activities. Components develop these plans without a common understanding of HHS's future.

We believe the Secretary and the organization would benefit in several ways from a departmental planning process. First, a planning process would help increase the Secretary's knowledge base about the departmental activities and programs by identifying current priorities and program status—a starting point from which to direct future activities. Second, a planning process would provide staff with a better sense of the policy and management preferences of the current leaders. Third, a

future vision for HHS programs can help the Department make realistic investments in the personnel, information, and financial systems that will be needed.

A workable planning system for the Department could take many different forms. The key feature must be its usefulness to the Secretary in developing and communicating a vision for the future of health and welfare programs.

The Secretary should initiate a departmental planning process that he or she can use to develop a common vision of the future direction of HHS's programs and operations.

Initiate Workforce Planning

HHS components do not have effective strategies for keeping their workforce matched to new work situations. For example, SSA has been trying to achieve a staff reduction of 17,000 by 1990 using attrition. The Department expects that increased productivity and the introduction of labor-saving technologies will help it achieve these staff reductions without degrading the quality of service. Through fiscal year 1988, SSA has lost about 12,000 positions—so far with continued high-quality service to the public. However, SSA is now trying to cut another 5,000 positions, and no one knows whether these

reductions can be achieved without affecting public service. So far SSA has been lucky that the attrition has caused no serious skill imbalances that we know of. However, without workforce planning, SSA does not know how extensive further reductions can be or how rapidly they can occur without serious consequences for service quality.

Also, other HHS agencies have no systematic workforce planning processes that allow them to adjust their workforce quickly and rationally when confronted with program changes and budget cuts. For example, HCFA had no means to forestall Office of Management and Budget-initiated staff cuts that reduced the agency's size by 20 percent at the same time that radical Medicare and Medicaid policy changes were being developed and implemented. Similarly, FDA and the Centers for Disease Control were without workforce planning tools that might have helped them add or redeploy staff to cope with the new demands of the AIDS epidemic.

The Secretary should introduce a more systematic approach to workforce planning to ensure that the Department's staffs are of the size and skill mix needed to operate its programs effectively.

Invest in Management Support Systems

When we have talked with new leaders at HHS, some have expressed surprise that so many programs lack modern financial and information systems. Many of the Department's principal accounting systems are more than 15 years old. Certain financial operations, such as making accurate payments, collecting debts owed the programs, and accounting for property, have not been conducted accurately or efficiently.

Component agencies have entered the "Information Age" slowly, despite the significance and size of their operations. For example, to develop information to support the prospective payment system, HCFA had to rely on overburdened SSA computers for information processing until hand-me-down computers from the National Institutes of Health were installed. As a result, HCFA was unable to answer a number of questions asked by the Congress and the Office of Management and Budget on the effects of changing Medicare to a prospective system.

In addition, the FDA capability to approve new drugs and monitor the safety of drugs on the market has been hampered by inadequate information systems. Similarly, because SSA has had trouble developing modern software to support its operations, retirees cannot get quick service when

reporting such things as the death of a spouse or a missing check.

Upgrading HHS's systems has generally proven difficult but worthwhile. A number of expensive projects to improve HHS's financial and information systems have failed to achieve their goals. However, when HHS has been successful at modernizing, substantial benefits have been obtained. For example, HHS has reported cumulative interest savings of $466 million from improved cash management activities. To successfully upgrade management systems in the Department, HHS needs top-level commitment to obtain staff with the needed skills for the job and to secure adequate funding for the activities.

The Secretary should ensure that HHS management systems are modernized by providing the necessary staff and funds to support such activities.

Restructure Role of Chief of Staff

Since 1981, secretaries of HHS have appointed chiefs of staff who have extensive involvement in the operations of the Department. The authorities of this office have not been formally established, but the incumbents have held a great deal of informal authority earned through the Secretary's trust. As currently structured, the

position has no public accountability or statutory basis.

The chiefs of staff at HHS have been informally assigned authorities that have already been formally delegated to others, thereby confusing accountability within the Department. For example, the Chief of Staff has operated with authorities commensurate to those of the Under Secretary. As a result, many Department managers question the need for both an Under Secretary and a Chief of Staff, citing redundancy of responsibility, unclear lines of authority, and role confusion between the incumbents. Similar confusions have existed among the Chief of Staff and other key Department principals, such as the Assistant Secretaries for Management and Budget and for Planning and Evaluation.

The organizational conflict inherent in the Chief of Staff position could be reduced by either (1) eliminating the position, (2) confining the responsibilities of the Chief of Staff to coordination of staff offices, or (3) reorganizing the Office of the Secretary to establish two principal deputies (for example, an Under Secretary for Management and an Under Secretary for Policy) with separate but equal responsibilities.

The Secretary should restructure the role of the Chief of Staff to prevent organizational confusion among key departmental leaders.

Financing the Cost of Health Care

Most of the federal funding for health care in the United States is channelled through Medicare and Medicaid. These programs are expected to cost taxpayers $129 billion in fiscal year 1989. These programs' costs have grown rapidly in the last 20 years, and substantial cost growth is expected to continue. While attempts to contain health care costs have been, at best, only partially successful, HHS must continue to pursue the cost-containment goal. GAO's work has identified a number of positive steps that the Secretary should take, including refining Medicare's hospital prospective payment system and improving controls over payments for physician and related services. The Secretary will also have to develop a strategy for addressing the long-term care problem.

Refine Medicare's Hospital Prospective Payment System

Medicare is the largest single source of payments for hospital services, with expenditures of over $50 billion in fiscal year 1988. In 1983, the program instituted a new prospective payment system (PPS) for hospitals under which a fixed amount is paid for all cases falling within a diagnosis related group (DRG)—a set of diagnoses expected to require about the same amount of hospital resources to treat.

PPS has succeeded in its primary objective of slowing the aggregate rate of growth in

Medicare's hospital costs. However, now that it has been in place for several years, some refinements are needed to assure greater equity in PPS rates.

Under PPS, hospitals are supposed to profit or lose based on their levels of efficiency, but whether this is the case is uncertain. PPS rates were based on 1981 unaudited cost data that reflected services provided under the incentives of Medicare's former cost reimbursement system. Our work has shown that the data included large amounts of unnecessary services and/or unallowable costs. Numerous changes and adjustments have been made to PPS rates, but they have not been rebased using data reflecting current hospital operations. What relationship, if any, PPS rates bear to the costs hospitals now incur is not known.

The Secretary should rebase PPS rates using current, audited cost data so that rates reflect hospital costs under the efficiency incentives of PPS.

Our analysis has also shown excessive variation in the costs of treating patients among the various diagnoses grouped under about a third of the DRGs. Particular types of hospitals predominately treat patients at the high-cost end of the wide

variation DRGs, while other types treat those mainly in the low-cost end. Thus, some types of hospitals are overcompensated and others undercompensated. The distortions also provide hospitals with incentives to seek or avoid treating patients with particular diagnoses that, in turn, could adversely affect beneficiary access to quality care.

To help assure equitable payments to hospitals, the Secretary should redefine DRGs to reduce the amount of intra-DRG variation in average treatment costs for covered diagnoses.

By statute, hospitals that have programs to train interns and residents receive higher payments under PPS than other hospitals. Our analysis has shown that the additional payments are higher than necessary to compensate these hospitals for the extra costs associated with teaching programs. Reducing the level of extra payments would substantially decrease Medicare costs.

The Secretary should seek to have the Medicare statute amended to permit reducing the level of extra payments to teaching hospitals to better reflect the additional costs associated with teaching programs.

Controlling Medicare Costs for Physician and Related Services

The costs of physician and other noninstitutional services covered under part B of Medicare has been increasing at a rate of over 15 percent per year. Past efforts to control these costs have largely failed. Savings from controls, such as payment freezes and limits on increases in charges, have been offset by higher use rates for services.

Medicare is currently moving toward the use of fee schedules for physician-related services, such as clinical laboratory tests and medical equipment used in the home, and relative value scales for physicians' services. These payment methods link rates to the time, effort, training, and other factors necessary to perform particular services or furnish items. These methods should help provide a more rational basis for service payments and more assurance of reasonable rates. By themselves, however, these payment reforms will not control overall costs because they will not control the quantity of services furnished.

The Secretary needs to come to grips with the issue of controlling service use. One step the Secretary should take is to develop benchmarks for the extent of services considered medically necessary to

treat specific illnesses and to require justification for paying for services exceeding those benchmarks.

One action that has been taken to control costs is paying a fixed amount for services through capitation programs, such as health maintenance organizations. The fixed amount is supposed to be 5 percent lower on average than Medicare would spend for the same beneficiaries under the traditional fee-for-service system. However, research has shown that for beneficiaries with the same health status, Medicare costs under the capitation method are the same or higher. The problem is that the current capitation rate-setting process does not adequately make distinctions in the health needs of people who enroll in capitation plans and those who do not; thus, it is not resulting in savings.

To help assure that the savings to Medicare envisioned from using the capitation method are realized, the Secretary should refine the methods used to compute Medicare capitation rates to better reflect the health status of beneficiaries.

Financing Long-Term Care

As more and more Americans live to an advanced age and are struck by chronic health problems, the demand for and the

overall costs of long-term care, both in the home and in nursing facilities, have and will continue to increase. The costs of this kind of care frequently are catastrophic, wiping out a lifetime of savings in a short period. How to assure access to long-term care without impoverishing those needing it has emerged as a dominant health issue for the elderly and their children.

Medicaid, with expenditures of about $20 billion, is the largest payer of nursing facility care. Similarly, Medicare has expenditures of over $2.5 billion making it the largest payer for home health care. The available commercial long-term care insurance has a number of shortcomings and may not be a financially viable option for many who are most in need of it. In July 1988, the Congress established the Commission on Long-Term Care to study and make recommendations on, among other things, long-term care financing mechanisms. The Commission is to issue a report in the spring of 1989, and the Secretary will have to react to any Commission recommendations.

The Secretary should develop a strategy and plan for an efficient and economical method of financing long-term care that considers the mix of private and public resources available to meet the need.

Financing and Delivering Social Security Benefits

No federal program attracts the attention of the Congress and the public like social security. It is the country's largest social program. Its receipts constitute the second largest source of federal revenue and its expenditures are second only to those of the defense budget. Since social security provides the foundation upon which most Americans build their retirement plans, any indication that promised benefits may not be paid is viewed by many as a threat to their own financial security.

From another perspective, the quality of services provided by social security employees plays a key role in shaping many citizens' view of the federal government because social security is one of the few federal programs with which almost every citizen comes into contact.

Because the social security program is so important and so visible, the Secretary should take special care to preserve the security of its financing, continue efforts to enhance public confidence in the program, and assure that SSA delivers high-quality service to the public.

Preserve the Social Security Trust Fund

Actions taken by the Congress in 1983, coupled with the recent national economic recovery, are putting the Social Security Trust Funds on a sound financial basis.

This is a far cry from the solvency crisis of 6 years ago. In 1988, total income will exceed outgo by about $44 billion, and accumulated reserves will be $112 billion by the end of the year. Reserves are expected to accumulate to $11.8 trillion by 2030 and are projected to be sufficient to pay benefits for the next 60 years.

The Congress and social security experts are beginning to debate the efficacy of building such large reserves. Some argue for delaying or reducing the scheduled payroll tax increase. Others suggest increasing benefits or using social security reserves to finance new domestic spending.

The primary concern of the Secretary should be to preserve the financial health of the social security program, both in the short run and into the next century. Whatever merit particular proposals might have, nothing should be done that would prevent the accumulation of a reserve sufficient to handle unforeseen fiscal contingencies; under current projections, it could take until 1993 or 1994 for reserves to reach these levels. Also, any changes made thereafter should at least maintain, and if possible enhance, the security of the benefit promises made to people who will be retiring in the 21st century.

A prudent course of action for the Secretary is to allow reserves to accumulate as currently scheduled until adequate contingency levels are realized. Thereafter, proposals dealing with alternative uses of trust fund reserves should be considered only if it is clear that they will not diminish assurances to future retirees.

Enhance Public Confidence in the Trust Fund

Workers have historically had little information about how much retirement income security the social security program will provide them. After well-publicized financial difficulties in the late 1970s and early 1980s, polls show that the public is still skeptical about whether the program is adequately financed and what funds will be available for them when they retire.

SSA recently started several actions to increase public awareness of social security, and improve confidence in the program. One key step has been to issue personal earnings and benefit statements to people who request them. These statements will help the public understand what they can expect from social security when they retire. Also, in March 1988, SSA was able to give the Congress audited financial statements showing the condition of the trust funds.

The Secretary should continue efforts to enhance public confidence in social security.

Improve Operations So That SSA Provides Quality Service Efficiently

SSA is responsible for paying benefits to about 39 million people and keeping earning records for most working Americans. In addition, it has contact with many millions of citizens each year. Therefore, most Americans have a stake in the efficiency of SSA's operations and the quality of services it delivers.

A key factor in managing an operation like SSA is a planning process, which guides policy, budget, and investment decisions in both the short and long term. SSA has long recognized the need for planning, but it has just recently developed a strategic planning process. Unless attention is given to completing all facets of that process and to making it work effectively, it could collapse. Key issues that need to be addressed are: identifying the specific functions that the agency will perform to support the type of service to the public envisioned by its strategic plan, determining the levels of service quality and timeliness to be achieved in the 21st century, and determining the level and type of resources needed to achieve its strategic planning goals.

SSA's operational efficiency depends in part on how well it uses new automated data processing (ADP) technology. Long described as antiquated and on the verge of collapse, its ADP system has undergone many improvements in the past decade. But the modernization cannot be completed until the key issues just cited are addressed and the ADP plan is modified to accommodate them. This will undoubtedly take time. In the meantime, SSA must keep the existing system running as efficiently and effectively as possible. Until SSA develops an ADP plan that supports the goals of the strategic plan, priority attention should be given to short-term ADP projects that maintain and improve service and, to the extent possible, facilitate systems modernization.

A related key factor in improving efficiency and, hence, service is better integration of all the technology-oriented functions namely ADP, telecommunications, software development, and data base maintenance. To accomplish this, SSA needs an information resource manager, with the responsibility and authority for setting policy and coordinating agency-wide activities relating to information resources.

The Secretary needs to assure that SSA completes all facets of its strategic planning process, adjusts its ADP plan accordingly, gives priority attention to short-term ADP projects that improve service, and appoints an agencywide information resource manager.

Develop Measures of Performance and Service Quality

To keep informed of its progress in providing quality service to the public and to allocate its resources towards the most important areas, SSA needs good performance indicators, work standards, and feedback systems. Currently, there is no systematic way for measuring public perception about the quality of all SSA services. Also, indicators used to measure performance have flaws and some important workloads are not measured at all. Historically, the agency has resisted the development of these management tools, but we think they are essential to running an efficient and effective operation particularly during times of staff cuts.

The Secretary should ensure that SSA develops and implements systems to measure the quality of the service it is providing. These should range from periodic surveys of public opinion about service to the development of operational performance indicators, which highlight how well

various operational units are doing their jobs.

Strong Leadership Needed to Implement Welfare Reform

The past two decades have seen a continuing welfare policy debate centered on how to provide needy families with the basic necessities of living without discouraging them from trying to support themselves. While the policymakers debated, the system achieved neither goal adequately.

In many respects, the recent welfare reform legislation represents a new political consensus that the Aid to Families With Dependent Children (AFDC) program should place increased emphasis on promoting parental responsibility through encouraging work efforts and collecting child support payments, instead of primarily providing cash assistance. The legislation also signals a consensus that the government must help recipients move toward self-sufficiency by assuming greater responsibility for providing them with training, education, and other employment-related services and for collecting child support from absent parents.

This legislation gives the new Secretary of HHS the opportunity to create a more effective welfare system. The new approach will not succeed, however, without vigorous leadership from HHS to assure effective implementation of the program.

Reorienting Welfare

In the past, most state AFDC agencies have focused on providing cash assistance to needy families. Ensuring that absent parents also contributed to their children's support and helping custodial parents become self-sufficient received less emphasis. Welfare reform seeks to balance and integrate these three functions, promoting the idea that welfare is temporary assistance. The Secretary should ensure that the concepts driving welfare reform are endorsed both within HHS and in the states.

Implementing welfare reform, however, will be difficult for several reasons. It requires reorienting the country's view of welfare's role and, at the local level, integrating cash assistance with child support and work/training efforts. However, paying out benefits at the right time and in the right amount is much easier than helping someone acquire the self-esteem and skills needed for work or collecting support from an absent parent whose whereabouts are unknown. In assuring that welfare reform's goals are met, HHS must assume roles that are not always compatible, assisting the states in implementing the new program while simultaneously monitoring compliance.

The Secretary must provide leadership to reorient the country's thinking about welfare and facilitate integration of welfare functions at the local level, balancing the roles of promoter and monitor of welfare reform.

Strengthening Programs to Promote Parental Responsibility

To increase the emphasis on promoting parental responsibility, welfare reform prescribes in detail many actions the states must take to provide employment-related services and enforce child support, and strengthens the federal role in overseeing these two functions. Based on our previous work, we believe several aspects of the new work/welfare and child support programs warrant special attention as HHS implements this legislation.

Three areas are particularly important in assuring that recipients obtain the education and skills they need to find jobs. First, welfare reform includes requirements and incentives for states to target services on long-term welfare recipients or those at risk of becoming long-term. We have found that some state programs currently may exclude these people from their work programs, because program performance is often judged by success rates in achieving short-term goals. HHS will have to assure that these states retarget their programs,

but it will also have to develop performance standards that recognize the difficulties in serving this group and are sensitive to the length of time needed to show results.

Second, the reform measure clearly intends that a comprehensive array of needed services, including education and training, be available to program participants. Our work has shown that while many current programs claim to offer these kinds of services, they do not actually provide them to many clients. HHS will have to ensure that participants who need more intensive services, such as education and training, actually receive them.

Third, welfare reform emphasizes the importance of child care, especially for women with children less than 6 years old. Some current programs offer this assistance only as a last resort and many do not monitor the quality of the care paid for by the program. HHS will have to ensure that assistance is readily available to participants and the care is of good quality.

The Secretary must ensure that states develop welfare employment programs that target people at risk of dependency, actually deliver the comprehensive

employment services these people need, and provide quality child care services.

In strengthening child support enforcement, welfare reform continues the movement of the 1984 Child Support Amendments to compel a stronger HHS involvement than the agency has chosen to exert in the past. Our work suggests three components that deserve special attention by the Secretary.

First, the reform legislation sets forth specific performance standards for determining paternity and requires the Secretary to include time limits for states to respond to requests for child support assistance. We have emphasized the need for such standards not only for paternity determination but for each child support service—locating absent parents, establishing support orders, and so on. Along with concerted efforts to establish performance standards for each child support service, the Secretary should ensure that HHS establishes procedures for monitoring states' performance in the future.

Second, the new law makes wage withholding automatic, starting 25 months after the law's enactment, even if support payments are not delinquent. In view of the lengthy time periods required by some

states in implementing the wage withholding requirements of the 1984 Amendments, we believe the Secretary should take steps to ensure states are prepared to implement this procedure as soon as the requirement takes effect. Also, the Secretary should explore ways to encourage states to use such other proven collection techniques as liens on real and personal property and credit bureau reporting.

Third, states must have in operation by October 1, 1995, statewide automated child support enforcement systems that meet requirements that the Secretary prescribes. Heretofore, such systems were optional, and the federal government provided incentives through enhanced funding available since 1981. In view of the relatively slow progress states have made developing such systems in the past—only two states' systems were fully operational as of May 1988—we believe the Secretary should ensure states are provided technical assistance in planning and designing these systems to meet the statutory deadline.

The Secretary should provide strong leadership to establish performance standards, encourage states to use proven support collection techniques, and aggressively

promote automated child support enforcement systems.

Related GAO Products

Financing the Cost of Health Care

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

HCFA Research: Agency Practices and Other Factors Threaten Quality of Mandated Studies (GAO/PEMD-88-9, June 3, 1988).

Medicare: Refinement of Diagnosis Related Groups Needed to Insure Payment Equity (GAO/HRD-88-41, Apr. 22, 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 2, 1987).

Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 29, 1987).

Medicaid: Determining Cost-Effectiveness of Home and Community-Based Services (GAO/HRD-87-61, Apr. 28, 1987).

Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments (GAO/HRD-86-25, Mar. 7, 1986).

Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (GAO/HRD-85-74, July 18, 1985).

Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision (GAO/HRD-85-39, Feb. 26, 1985).

Excessive Respiratory Therapy Cost and Utilization Data Used in Setting Medicare's Prospective Payment Rates (GAO/HRD-84-90, Sept. 28, 1984).

Medicare and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly (GAO/IPE-84-1, Oct. 21, 1983).

Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services (GAO/HRD-83-16, Feb. 8, 1983).

Social Security

Social Security Administration: Stable Leadership and Better Management Needed to Improve Effectiveness (GAO/HRD-87-39, Mar. 18, 1987)

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Social Security: Staff Reductions and Service Quality (GAO/HRD-87-139BR, Sept. 17, 1987)

Social Security: Clients Still Rate Quality of Service High (GAO/HRD-87-103BR, July 14, 1987)

	Social Security: Improved Telephone Accessibility Would Better Serve the Public (GAO/HRD-86-85, Aug. 29, 1986)
	Social Security: Issues Relating to Agency Field Offices (GAO/HRD-86-71BR, Mar. 31, 1986)
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	Quality of Services Generally Rated High by Clients Sampled (GAO/HRD-86-8, Jan. 30, 1986)
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Welfare Reform	Welfare Reform: Projected Effects of Requiring AFDC for Unemployed Parents Nationwide (GAO/HRD-88-88BR, May 23, 1988)
	Problems GAO Identified in Work on Child Support Enforcement Program (GAO/T-HRD-88-8, Feb. 23, 1988)

Welfare: Expert Panels' Insights on Major Reform Proposals (GAO/HRD-88-59, Feb. 3, 1988)

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Findings on Current AFDC Work Programs and Implications for Pending Legislation (GAO/T-HRD-87-12, Apr. 30, 1987)

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Observations on How the Office of Child Support Enforcement Could Better Help States Efficiently Automate Their Child Support Enforcement Programs (GAO/IMTEC Letter B-221220, Feb. 20, 1987)

Welfare: Issues to Consider in Assessing Proposals for Reform (GAO/HRD-87-51BR, Feb. 19, 1987)

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Child Support: States' Progress in Implementing the 1984 Amendments (GAO/HRD-87-11, Oct. 3, 1986)

Child Support: States' Implementation of the 1984 Child Support Enforcement Amendments (GAO/HRD-86-40BR, Dec. 24, 1985)

Evidence Is Insufficient to Support the Administration's Proposed Changes to AFDC Work Programs (GAO/HRD-85-92, Aug. 27, 1985)

U.S. Child Support: Needed Efforts Underway to Increase Collections From Absent Parents (GAO/HRD-85-5, Oct. 30, 1984)

Child Support Collection Efforts for Non-AFDC Families (GAO/HRD-85-3, Oct. 30, 1984)

CWEP's Implementation Results to Date Raise Questions About the Administration's Proposed Mandatory Workfare Program (GAO/PEMD-84-2, Apr. 2, 1984)

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